Patient Identification Information

JHBMC COMMUNITY PSYCHIATRY PROGRAM
ADOLESCENT INTENSIVE OUTPATIENT PROGRAM
PATIENT DATA FILE

Attach most recent supporting documentation (i.e. Diagnostic Note, Admission Note, Progress Note Psychosocial, Treatment Plan, Psych Testing/Evaluation, Guardianship/ Kinship Care Forms)

Referral Date (MM/DD/YY)**:** _____ **Referring Provider Name:** _____
Referral Agency: _____ **Phone #:** _____

Patient Name (last, first, middle)**:** _____
JHBMC Number (000-00-00): _____ **Date of Birth** (MM/DD/YY)**:** _____
Phone(s) #: _____ **Patient E-mail** (if available)**:** _____
Address, City, State, Zip: _____
Parent/Legal Guardian Name #1: _____ **Relationship to Patient:** _____
Phone(s) #: _____ **Email:** _____
Parent/Legal Guardian Name #2: _____ **Relationship to Patient:** _____
Phone(s) #: _____ **Email:** _____
Race, Ethnicity and Preferred Language: _____
Legal Sex: ☐Male ☐Female **Gender Identity**: ☐ Male ☐ Female ☐ Non-Binary ☐ Other:_____ **Pronouns:** _____
School: _____ **School Grade:** _____

Insurance (Indicate Primary and Secondary if applicable):
☐CareFirst/ BCBS ☐ Cigna ☐ EHP ☐ Tricare (USFHP) ☐ Medical Assistance ☐ Medicare ☐ Aetna Other:_____
Insurance Policy#: _____
**For CareFirst/ BCBS Include Copy of Insurance Card

Additional Emergency Contacts (name, relationship, address and phone number(s); please note if none available):
Emergency Contact #1: _____ **Relationship to Patient:** _____
Phone(s) #: _____ **Email:** _____
Emergency Contact #2: _____ **Relationship to Patient:** _____
Phone(s) #: _____ **Email:** _____

SI Screen **Required for all referrals ages 8+
In the past week have you/your child wished you/your child could go to sleep and not wake up? ☐Yes☐No
In the past week have you/ your child had any actual thoughts to kill yourself/him? ☐Yes☐No
Crisis Resources provided: ☐ 911 ☐ 988 ☐ Closest ED ☐ BCARS ☐ BHSB First Call For Help ☐ County Crisis Response
Other: _____

Referral Diagnosis (ICD-10)**:** _____
Mental Health Provider (if applicable): _____
PCP (name, address, phone number): _____
Current Medications: _____

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Reason for Referral/ Presenting Concern (i.e. symptoms, previous hospitalizations, ED visits, substance use, trauma, disordered eating, developmental issues: _____

_____

_____

_____

Patient's Strengths:

_____

Patient's Current Needs:

_____

Goal Areas to be Addressed:

☐ Physical/ Nutritional ☐ Emotional/Behavioral ☐ Social/ Family ☐ Activity/ Recreation ☐ Entitlements/ Financial
☐ Vocational/ Educational ☐ Legal ☐ Environmental ☐ Other: _____

Initial Goals:

_____

Current Symptoms:

☐ ADHD ☐ Anxiety ☐ Adjustment ☐ Cognitive ☐ Conduct ☐ Depression ☐ Developmental ☐ Eating
☐ Elimination ☐ Gender Dysphoria ☐ Homicidal Ideation ☐ Learning ☐ Mania ☐ OCD ☐ ODD ☐ PTSD
☐ Psychosis ☐ Self-Harm ☐ Sexual ☐ Sleep ☐ Somatic ☐ Speech/ Language ☐ Substance Use/ Abuse
☐ Suicidal Ideation ☐ Other: _____

Current Psychosocial Stressors:

☐ Financial ☐ Educational ☐ Housing ☐ Occupational ☐ Other Psychosocial/ Environmental ☐ Legal System/ Crime
☐ Social Environment ☐ Health Care Access ☐ Primary Support Group ☐ Other: _____

Barriers to Treatment:

☐ No barriers identified ☐ Language ☐ Cognitive ☐ Visual Impairment ☐ Reading ☐ Hearing Impaired ☐ Cultural/ Religious
☐ Physical Disability ☐ Communication ☐ Desire/ Motivation ☐ Transportation ☐ Time ☐ Unable to identify resiliency factors
☐ Other: _____

Treatment History (What's worked, what hasn't, what's needed?): _____

_____

Agencies Currently Involved & Contact: _____

☐ DSS/CPS ☐ DJS ☐ Housing ☐ School IEP/ 504 ☐ Other: _____

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INTERNAL USE ONLY		
Therapist/ Appt. Date/Time:		
Rescheduled: Therapist/ Appt. Date/ Time:		
Notes:		
COMMERCIAL INSURANCE NAME (PRIMARY):		
☐YES ☐NO		
Claims Address:		Phone #:
Contact:		Send Claims To:
If secondary to Medicare, will Medicare automatically roll over? ☐YES ☐NO		
Member/ Policy #:		Effective Date:
ARE WE IN NETWORK? ☐YES ☐NO		
In Network Coverage:	Ded. Amount:	Ded. Met:
How many CPT Codes/ visit/ calendar plan/ year?		
Out of Network Coverage:	Ded. Amount:	Ded. Met:
How many CPT Codes/ visit/ calendar plan/ year?		
Subscriber's Employer:		
Subscriber, if different than patient:		Relationship to Patient:
Patient responsible for Physician/ Professional Charge:		*Therapist Charge:*
Facility Fee:		
Services Covered:		
Outpatient: ☐YES ☐NO		Inpatient: ☐YES ☐NO
Intensive Outpatient: ☐YES ☐NO		PHP/ Day Hospital: ☐YES ☐NO
Authorization Required? ☐YES ☐NO		Authorization #:
COMMERCIAL INSURANCE (SECONDARY): ☐YES ☐NO		
Insurance Provider:		Member/ Policy #:
MEDICAL ASSISTANCE:		
Authorized at: ☐341475200 (JHBMC) ☐ 046611500 (SBMCH)		Carelon ID#:
MA Member/ Policy #:		
Effective Date(s):		# of visits:
MEDICARE		
Member/ Policy #:		Effective Date:
Is Medicare Primary or Secondary? ☐Primary ☐ Secondary		
20% co-pay for Medicare covered by:		
TAP		
Tap approval letter must be attached to PDF and scanned.		
If patient does not have TAP approval letter or TAP office cannot fax authorization, letter for mental health treatment the patient cannot be seen by therapist.		
If patient is attended for the intake without TAP approval in place, a bill will be generated and sent to the family.		